

Date of interview

Day/Month/Year

AFFIX STUDY LABEL HERE

- 1 What year were you born? Year=  Don't know ☐ Refused ☐
- 2 Sex: Female ☐ Male ☐ Don't know ☐ Refused ☐
- 3 What ethnic group do you most identify with? Don't know ☐ Refused ☐
- Caucasian ☐ Asian ☐ Aboriginal ☐ Other ☐ Don't know ☐
- If aboriginal ☐ Metis ☐ Inuit ☐ First Nation ☐
- If First Nation ☐ Status ☐ Non-status ☐
- 4 Do you have a job? Full time ☐ No Job ☐ Don't know ☐ Refused ☐
- Part-time ☐ Casual or Day Labour ☐
- 5 What are some other ways you get or make money? Don't know ☐ Refused ☐
- AISH ☐ EI ☐ Welfare ☐ Other way
- 6 Have you lived in Calgary for the last 2y? Yes ☐ No (go to #8) ☐ Refused ☐
- 7 How long have you lived in Calgary < 1 month ☐ 1-3 months ☐ 4 month-1y ☐ >1 y ☐
- 8 In the last 6 months what kinds of places have you lived in? (check all that apply)

At all

☐  
☐  
☐  
☐  
☐  
☐  
☐  
☐  
☐  
☐  
☐

Own apartment /house  
Friend's place  
Hotel or motel room  
Roaming or boarding house  
Transition or half way house  
On the street  
Jail  
Shelter or detox house  
Don't know  
Refused

Living now

☐  
☐  
☐  
☐  
☐  
☐  
☐  
☐  
☐  
☐  
☐

9 If in jail

How long was your longest stay in the past 6m?

☐ <1week  
☐ >1w but <1m  
☐ >1month  
☐ Don't know  
☐ Refused

- 10 If you have lived in a shelter or detox centre which ones? (check all that apply)

Alpha house ☐

Renfrew Recovery ☐

Simon House ☐

Aventa ☐

Servants Anonymous Soc ☐

Fresh start ☐

Sunrise residence ☐

Other

Mustard seed ☐

Drop-in Ctr ☐

Centre of Hope ☐

The Warehouse ☐

The Booth ☐

Sunalta/2035 ☐

Centre 16 ☐

Electrical Station ☐

Don't know ☐

Refused ☐

- 11 In the place you live in now, how many people do you live with? Don't know
- ☐
- Refused
- ☐

- 12 Which neighbourhood do you spend most of your time in? (not sleeping or for job)

Bowness ☐ Downtown ☐ Other NW ☐ Other SE ☐

Forest Lawn ☐ Inglewood ☐ Other NE ☐ Don't know ☐

Victoria Park ☐ Albert Park ☐ Other SW ☐ Refused ☐

The next set of questions are about drugs and alcohol. We are asking everyone in this study the same questions.

- 13 How often do you drink alcohol?

Almost everyday ☐ Several times a month ☐ Don't know ☐

Several times a week ☐ Rarely or never ☐ Refused ☐

14 In the past 6 months, have you used any recreational drugs? Yes ☐ No (go#22) ☐ Refused ☐

15 In the past 6 months, which of the following drugs have you used? (check all that apply)

inject	smoke	other
Cocaine <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crack cocaine <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morphine other narcotics <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine+morphine <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine+heroin <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crystal meth <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other drugs <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't use drugs (go to # 20) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't know <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Refused <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16 Which drug do you use most often? (check one)

17 For the drug you use most often, how often do you use this drug?

>5 times a day <input type="checkbox"/>	<5 days a week <input type="checkbox"/>	Don't know <input type="checkbox"/>
<5 times a day but > once <input type="checkbox"/>	Once a week <input type="checkbox"/>	Refused <input type="checkbox"/>
Once a day <input type="checkbox"/>		

18 In the last 6 months did you go on runs or binges when you used drugs more than usual?

Yes ☐  
 No (go to # 21) ☐  
 Don't know ☐  
 Refused ☐

19 How many times did you binge?

\_\_\_\_\_ times per month  
 \_\_\_\_\_ times in 6 months

20 How long did they last?

1 day ☐  
 2-5 days ☐  
 >5 days ☐  
 Don't know ☐  
 Refused ☐

21 In the past 6 months, who have you used drugs with? (check all that apply)

Regular sex partner(s) ☐  
 Casual sex partner (s) ☐  
 With a date or a STW ☐  
 Close friends or family ☐

People you don't know well ☐  
 People you don't know at all ☐  
 Always use alone ☐  
 Don't know ☐

Refused ☐

22 In the past 6 months, have you lived with someone who uses drugs?

Yes ☐  
 No (go to # 24) ☐  
 Don't know ☐  
 Refused ☐

23 Which drugs did this person use? (check all that apply)

Cocaine ☐  
 Crack cocaine ☐  
 Morphine/other narcotics ☐

Heroin ☐  
 Crystal meth ☐  
 Other drugs ☐  
 Don't know ☐

The next set of questions are related to your life in Calgary

24 In the last 6 months how often have you eaten at any community dinners or soup kitchens?

Never ☐  
 Once a week ☐  
 2-4 times/week ☐  
 >5times/week ☐  
 Daily ☐  
 Don't know ☐  
 Refused ☐

25 Which ones? (check all that apply)

Mustard seed ☐  
 Alpha house ☐  
 Centre of hope ☐  
 Drop-in Ctr ☐  
 Inn from the cold ☐

St Mary's ☐  
 The Booth ☐  
 CUPS/FRC ☐  
 Other: \_\_\_\_\_  
 Refused ☐

The next set of questions are about how your health has been recently

26 In the last 2 years, have you been admitted to the hospital?

Yes ☐  
 No ☐

27 How many times in the last:

6 months \_\_\_\_\_  
 1 year \_\_\_\_\_  
 2 years \_\_\_\_\_

28 **For the last hospitalization**

a **How long ago were you in hospital?**

<1 month	<input type="checkbox"/>
1-6 months	<input type="checkbox"/>
7-12 mos	<input type="checkbox"/>
>1 year	<input type="checkbox"/>
Don't know	<input type="checkbox"/>
Refused	<input type="checkbox"/>

b **How many days were you in hospital for?**

<24 hours	<input type="checkbox"/>
1-3 days	<input type="checkbox"/>
4-7 days	<input type="checkbox"/>
>week	<input type="checkbox"/>
Don't know	<input type="checkbox"/>
Refused	<input type="checkbox"/>

c **Why were you admitted to hospital?**

(check one)

Surgery (emergency or planned)	<input type="checkbox"/>
Medical reason	<input type="checkbox"/>
Psychiatry	<input type="checkbox"/>
Other reason	<input type="checkbox"/>
Don't know	<input type="checkbox"/>
Refused	<input type="checkbox"/>

d **Did any of the following things happened while you were in hospital?**

Stay in ICU	<input type="checkbox"/>	Endotracheal tube	<input type="checkbox"/>
Nasogastric tube	<input type="checkbox"/>	Don't know	<input type="checkbox"/>
Urinary catheter	<input type="checkbox"/>	Refused	<input type="checkbox"/>
Dialysis	<input type="checkbox"/>		
IV catheter	<input type="checkbox"/>		

29 **Have you taken or received any antibiotics in:**  
**Last 6 months?**

Yes ☐

No ☐

30 **In the last 2 weeks**

Have you had any pimples or boils	<input type="checkbox"/>	Have you had any infected wound or cut	<input type="checkbox"/>
Face	<input type="checkbox"/>		<input type="checkbox"/>
Back	<input type="checkbox"/>		<input type="checkbox"/>
Upper thighs	<input type="checkbox"/>		<input type="checkbox"/>
Genitalia	<input type="checkbox"/>		<input type="checkbox"/>
Injection site	<input type="checkbox"/>		<input type="checkbox"/>
Other	<input type="checkbox"/>		<input type="checkbox"/>

31 **In the last 6 months**

Have you had any pimples or boils	<input type="checkbox"/>	Have you had any infected wound or cut	<input type="checkbox"/>
Face	<input type="checkbox"/>		<input type="checkbox"/>
Back	<input type="checkbox"/>		<input type="checkbox"/>
Upper thighs	<input type="checkbox"/>		<input type="checkbox"/>
Genitalia	<input type="checkbox"/>		<input type="checkbox"/>
Injection site	<input type="checkbox"/>		<input type="checkbox"/>
Other	<input type="checkbox"/>		<input type="checkbox"/>

Yes ☐

No ☐

Refused ☐

32 **Did you get a doctor or nurse to look at these infections?**

33 **Did you squeeze, pop or cut them on your own?**

34 **Did someone else squeeze, pop or cut them for you?**

35 **Did you take antibiotics for them?**

36 **In the past 6 months have you lived with or been in close physical contact with anyone with a skin infection?**

37 **Have you ever been diagnosed with:**

(check all that apply)

Hepatitis C	<input type="checkbox"/>	CD4 count _____ date _____
Hepatitis B	<input type="checkbox"/>	
HIV	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	
Skin condition (psoriasis, acne eczema)	<input type="checkbox"/>	
A heart valve infection endocarditis	<input type="checkbox"/>	

A bone infection (osteomyelitis)	<input type="checkbox"/>
A joint infection (septic arthritis)	<input type="checkbox"/>
Lung condition (chronic)	<input type="checkbox"/>
A kidney disease (chronic)	<input type="checkbox"/>
A liver condition (no hepatitis B/C)	<input type="checkbox"/>
Cancer	<input type="checkbox"/>
Don't know	<input type="checkbox"/>
Refused	<input type="checkbox"/>

*The next section deals with sexual practices*

38 **In the last 6 months:**

a **How many different partners of the same gender have you have sex with:**

<input type="checkbox"/>	None
<input type="checkbox"/>	1
<input type="checkbox"/>	2-5
<input type="checkbox"/>	6-10
<input type="checkbox"/>	11-20
<input type="checkbox"/>	>20

b **How many partners of the opposite gender have you had sex with:**

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

39 **Do you use condoms?**

Never ☐ Sometimes ☐

Almost always ☐

Always ☐

**If sexual partner of same gender. In the last 6 months...**

Yes

No

40 **Have you practice receptive oral sex**

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

41 **Have you practiced receptive anal sex (bottom)**

42 **Have you practiced insertive anal sex (top)**

43 **What are your usual sexual practices (check all that apply:**

Insertive anal sex ☐  
Receptive anal sex ☐

Oral sex ☐  
Mutual masturbation ☐

*This section deals with body grooming patterns and sport activities*

44 **Do you have any peircings?**

Yes ☐  
No ☐  
Refused ☐

45 **Where are your peircings? (check all that apply)**

Belly button ☐  
Penis/labia ☐  
Testicles ☐  
Ear lobe ☐

Perineum ☐  
Nose ☐  
Tonge ☐  
Nipple ☐

46 **Do you remove your pubic hair?**

Yes ☐  
No ☐

Shave ☐

Wax ☐

Trim ☐

47 **Do you participate regularly in any of the following sports? (check all that apply)**

Football ☐  
Hockey ☐  
Wrestling ☐

Soccer ☐  
Swimming ☐  
Weightlifting ☐

48 **In what capacity do you participate?**

Team player ☐  
Coach ☐  
I do not play ☐

49 **Do you attend the gym?**

Yes ☐  
No ☐  
Refused ☐

50 **What activities you indertake in the gym?**

Weights ☐  
Cardio ☐  
Yoga ☐  
Pilates ☐

Swimming ☐  
Hot tub ☐  
Steam room ☐  
Sauna ☐

Shower at the gym ☐

Can you show me ALL the skin infections that you have right now? I would like to have a look at them and if possible take a swab.

A skin infection must meet the following criteria:

- 1 A wound with purulent drainage; or pustules, vesicles or boils with or without purulent drainage OR
- 2 Two of the following at an affected site: localized pain or tenderness, swelling, redness or heat.

Swabs should be collected if the infection is open or draining, or if the infection is a pustule or other superficial contained collection of pus. Deeper or non-pustular lesions such as boils or abscesses which are not draining should not be swabbed.

If the participant identifies more than two skin infections: priority should first be given to infections that can be swabbed as described above, and then to infections that in your clinical judgment appear to be most severe. Please record information on up to two infections even if they cannot be swabbed.

<b>1 Infection site # 1</b>	<b>Localization</b> _____		
<b>2 Type of infection:</b> (check one)			
Infected wound, cut, laceration, injury	<input type="checkbox"/>	Blister	<input type="checkbox"/>
Pustule (folliculitis)	<input type="checkbox"/>	Cellulitis	<input type="checkbox"/>
Boil (furuncle, carbuncle)	<input type="checkbox"/>	Impetigo	<input type="checkbox"/>
		Other	<input type="text"/>
<b>3 Is this infection site:</b> (check one)		<b>Swabbed</b>	<b>Labeled Infection1</b>
Open or draining purulent-material (should swab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open or draining non-purulent material (should swab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not open or draining, but is a superficial collection of pus or pustule (swab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not open or draining, with no superficial collection of pus (don't swab)	<input type="checkbox"/>		
<b>4 Was the infection an injection site that became infected?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
<b>5 What other characteristics does this infection have?</b> (check all that apply)			None of the above <input type="checkbox"/>
Redness	<input type="checkbox"/>	Swelling	<input type="checkbox"/>
Localized pain or tenderness	<input type="checkbox"/>	Heat	<input type="checkbox"/>
<b>6 Was the participant referred on to medical care because of this infection?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>

<b>1 Infection site #2</b>	<b>Localization</b> _____		
<b>2 Type of infection:</b> (check one)			
Infected wound, cut, laceration, injury	<input type="checkbox"/>	Blister	<input type="checkbox"/>
Pustule (folliculitis)	<input type="checkbox"/>	Cellulitis	<input type="checkbox"/>
Boil (furuncle, carbuncle)	<input type="checkbox"/>	Impetigo	<input type="checkbox"/>
		Other	<input type="text"/>
<b>3 Is this infection site:</b> (check one)		<b>Swabbed</b>	<b>Labeled Infection2</b>
Open or draining purulent-material (should swab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open or draining non-purulent material (should swab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not open or draining, but is a superficial collection of pus or pustule (swab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not open or draining, with no superficial collection of pus (don't swab)	<input type="checkbox"/>		
<b>4 Was the infection an injection site that became infected?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
<b>5 What other characteristics does this infection have?</b> (check all that apply)			None of the above <input type="checkbox"/>
Redness	<input type="checkbox"/>	Swelling	<input type="checkbox"/>
Localized pain or tenderness	<input type="checkbox"/>	Heat	<input type="checkbox"/>
<b>6 Was the participant referred on to medical care because of this infection?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>